Attachment I

SC Department of Disabilities and Special Needs

Request for Reinstatement of Employee Form

Provider:	
Name of Employee Recommended for Reinstatement:	
Date of Incident:	**If Date of Incident is unknown, indicate date incident was reported** (also shown on Initial Report):
Name(s) of Alleged Victim(s) Involved in Incident:	
Reason employee should be reinstated:	

Provider Signature:

_____ _____

Executive Director/ CEO/ Facility Administrator — Date

Central Office Action Regarding Employee Reinstatement:	**Signatures:**
☐ Approved Comments:	_____ _____ Office of Quality Management — Date
☐ Disapproved Comments:	_____ _____ Office of Quality Management — Date
☐ Approved Comments:	_____ _____ Office of Policy — Date _____ _____ Office of Operations — Date
☐ Disapproved Comments:	_____ _____ Office of Policy — Date _____ _____ Office of Operations — Date

Note: A separate form should be completed for each employee where employment reinstatement is being requested.

Send completed form to:
Director of Quality Management, SCDDSN, PO Box 4706, Columbia, SC 29240, FAX #: 803-898-7450.

Form for Policy 534-02 DD; Form Effective 1/12/09